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A Montana guide
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in Federal and
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A Montana Guide to Recent Changes in Federal and State Health Insurance Laws

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This guide is intended to help consumers understand their protections under federal and state law. The authors have made every attempt to assure that the information presented in this guide is accurate as of the date of publication. However, this guide is a summary, and should not be used as a substitute for legal, accounting, or other expert professional advice. Readers should consult insurance regulators or other competent officials for guidance in making health insurance decisions. The authors, Georgetown University, and the Institute for Health Care Research and Policy specifically disclaim any personal liability, loss or risk incurred as a consequence of the use and application, either directly, or indirectly, of any information presented herein.

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A MONTANA GUIDE TO RECENT CHANGES IN FEDERAL AND STATE HEALTH INSURANCE LAWS

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), better known as *Kassebaum-Kennedy*. This law, plus Montana's health insurance reforms, protects you when you seek to buy, keep, or switch your health insurance, even if you have a serious health condition.

This guide describes your protections as a Montana resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health plans. Chapter 4 highlights your protections as a small employer. If you move away from Montana, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information, see page 18. A list of helpful terms and their definitions begins on page 19. These terms are printed in *boldface* type the first time they appear.

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CHAPTER 1
A SUMMARY OF YOUR PROTECTIONS

Kassebaum-Kennedy is supposed to make it easier for people with **preexisting conditions** to get or keep **health insurance**, or to change from one **health plan** to another. This law sets national standards for all health plans. Since states can pass different reforms for the health insurance plans they regulate (**fully insured group health plans** and **individual health plans**), your protections may vary if you leave Montana. Neither federal nor state laws protect your access to health insurance in all circumstances. So please read this guide carefully.

The following information summarizes how federal and state laws do – or do not – protect you as a Montana resident.

HOW AM I PROTECTED?

In Montana, as in many other states, your health insurance options are somewhat dependent on your **health status**. Even if you are sick, however, the laws protect you in the following ways.

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more because of your health status.* This is called **nondiscrimination**. (See page 5.)

- *All group health plans in Montana must limit exclusion of preexisting conditions.* There are rules about what counts as a preexisting condition and how long you must wait before a new group health plan will begin to pay for care for that condition. Generally, if you join a new group health plan, your old coverage will be credited toward the **preexisting condition exclusion period**, provided you did not have a long break in coverage. (See page 7.)

- *Your health insurance cannot be canceled because you get sick.* Most health insurance is **guaranteed renewable**. (See pages 10 and 15.)

- *If you leave your job, you may be able to remain in your old group health plan for a period of time.* This is called **COBRA** continuation coverage. It can help when you are between jobs or waiting for a new health plan to cover your preexisting condition. There are limits on what you can be charged for this coverage. (See page 11.)

- *If you lose your group health insurance and meet other qualifications, you will be **federally eligible.*** If so, you can buy an individual health plan from the Montana Comprehensive Health Association (**MCHA**) high risk pool. All your preexisting conditions will be covered immediately under the benefits provided. Premiums will vary based on your age. (See page 13.)

- *You can also buy insurance from MCHA if you have been turned down by at least two health insurance companies or have a serious health condition and meet other qualifications.* In this case you may face a new preexisting condition exclusion period if you haven't had coverage lately.

- *If you lose your group coverage under a fully insured group health plan and meet other qualifications, you also can buy a **conversion** policy.* There are limits on what you can be charged for a conversion policy, although they tend to be costly. (See page 13.)

- *If you are a small employer buying a group health plan, you and your employees and dependents cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group.* This is called **guaranteed issue**. (See page 15.)

- *If you are a small employer buying a group health plan, there are limits on what you can be charged because of health status, age, or other characteristics of those in your group.* (See page 16.)

WHAT ARE THE LIMITS ON MY PROTECTIONS?

As important as they are, the federal and state health insurance reforms are limited. Therefore, you also should understand how the laws do *not* protect you.

- *If you change jobs, you usually cannot take your old health benefits with you.* Except when you exercise your COBRA continuation rights, you are not entitled to take your actual group health plan with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did.

- *If you change jobs, your new employer may not offer you health benefits.* Employers are required only to make sure that their decision is based on factors unrelated to your health status.

- *If you get a new job with health benefits, your coverage may not start right away.* Employers and health maintenance organizations (**HMOs**) can require **waiting periods** before your health benefits begin. (See page 6.)

- *If you work for certain non-federal public employers in Montana, not all of the group health plan protections may apply to you.* (See page 5.)

- *If you have a break in coverage of 63 days or more, you may have to satisfy a new preexisting condition exclusion period when you join a new group health plan or MCHA.* (See pages 7 and 13.)

- *Even if your coverage is* ***continuous****, there may be a preexisting condition exclusion period for some benefits if you join a group health plan that covers certain benefits your old plan did not.* For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new health plan will pay for drugs prescribed to treat a preexisting condition. (See page 9.)

- *In Montana, your access to individual health insurance may depend on your health status.* Individual health plans in Montana are not prohibited from turning you down, charging more, or limiting coverage because of preexisting conditions. If you are eligible, MCHA is your only guaranteed access to individual health insurance, though you may be able to buy individual coverage from other insurance companies.

  Once you obtain coverage, your ability to switch plans may be limited as well. While you have protections when you move from an individual policy to a group plan, Montana law does not provide the same protections when you move from one individual plan to another, even if you had prior continuous coverage. (See page 10.)

CHAPTER 2
YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

Your protections under a group health plan will vary somewhat, depending on whether it is a fully insured group health plan or a **self-insured group health plan**. The plan's benefits information must indicate whether the plan is self-insured.

If you are in or just joining a group health plan, many of these protections under federal and state law are explained below. For most other plans, they become effective when the **health plan year** begins or renews after June 30, 1997, but no later than July 1, 1998.

Kassebaum-Kennedy permits state, county, and local governments to exempt their employees in self-insured plans from some of these protections. Public employers must make this choice annually. In Montana, seven employers (listed in box below) are exercising this choice for the 1998 plan year. If you have group health coverage through these employers, you may want to contact them for more information. Other non-federal public employers in Montana may have made this choice after this guide was written. If you are not sure about your protections under your public employee health plan, you may want to contact your employer.

Montana public employers electing to exempt their covered employees from Kassebaum-Kennedy protections during 1998 plan year

Barrett Memorial Hospital
Big Horn County
Billings Public Schools
Cascade County
Columbia Falls School District #6
Liberty County
Powell County High School

WHEN DOES A GROUP HEALTH PLAN HAVE TO LET ME IN?

- *You have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. Or, your employer may offer an HMO plan that you cannot join because you live outside of the plan's service area.

- *You cannot be turned away or charged more because of your health status.* This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part time employment) as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

The Acme Company offers two different health plans. Managers are offered a high option plan that covers prescription drugs; everyone else is offered a low option plan that does not. This is *permitted* under the law. By contrast, in a cost-cutting move, Acme restricts its high option plan to those managers who can pass a physical examination. This is *not permitted* under the law.

- *You must be given a special opportunity to sign up for your group health plan if certain changes happen to your family.* In addition to any regular **enrollment period** your employer or group health plan offers, you must be offered a special, 30-day opportunity to enroll in your group health plan after certain events. You can elect coverage at this time. If your group health plan offers family coverage, your dependents can elect coverage, as well. Enrollment during a **special enrollment period** is *not* considered **late enrollment.**

Certain changes can trigger a special enrollment opportunity

- The birth, adoption, or placement for adoption of a child
- Marriage
- Loss of other coverage (for example, that you or your dependents have through yourself or another family member because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)

- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage.* These waiting periods, however, must be applied consistently and cannot vary due to your health status.

- *When you begin a new job with health insurance through an HMO, the HMO may require a waiting period before coverage begins.* This waiting period is called an HMO **affiliation period**, and you will not have health insurance coverage during this time. An affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during it.

CAN A GROUP HEALTH PLAN LIMIT MY COVERAGE FOR PREEXISTING CONDITIONS?

When you first enroll in a group health plan, the employer or insurance company may ask if you have any preexisting conditions. Or, if you make a claim during the first year of coverage, the plan may look back to see whether it was for such a condition. If so, it may seek to exclude coverage for services related to that condition for a certain length of time. However, federal and state laws protect you by placing limits on these preexisting condition exclusion periods under group health plans.

- *If you join a new group health plan, the law protects you from a new preexisting condition exclusion period, provided you maintain continuous* ***creditable coverage****.* Coverage counts as continuous if it is not interrupted by a break of *63 or more days* in a row.

  In determining continuous coverage, employer-imposed waiting periods and HMO affiliation periods do not count as a break in coverage. If your new plan imposes a preexisting condition exclusion period, you can credit time under your prior continuous coverage toward it. If your employer requires a waiting period, the preexisting condition exclusion period begins on the first day of the waiting period. HMOs that require an affiliation period cannot exclude coverage for preexisting conditions.

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

Federal Employees Health Benefits (FEHBP)
Group health insurance (including COBRA)
Indian Health Service
Individual health insurance
Medicaid
Medicare
Military health coverage (CHAMPUS)
State health insurance high risk pools

In most cases, you should get a **certificate of creditable coverage** when you leave a health plan. You also can request certificates at other times. If you cannot get one, you can submit other proof, such as old health plan ID cards or statements from your doctor showing bills paid by your health insurance plan.

What is continuous coverage?

You can get continuous coverage under one plan, or under several plans as long as you don't have a lapse of 63 or more consecutive days.

Take Art, who has diabetes. Ajax Company covered him under its group health plan for 9 months, but he lost his job and health coverage. Then, *45 days later*, Art found a new job at Beta Corporation and had health coverage for 9 more months. Art changed jobs again. His new company, Charter, has a health plan that covers care for diabetes but excludes preexisting conditions for 12 months. Charter must cover Art's diabetes care immediately, because his 18 months of prior continuous coverage are credited against the 12-month exclusion.

Now consider a slightly different situation. Assume Art was uninsured for *90 days* between his jobs at Ajax and Beta. In this case, Charter will credit coverage only under Beta's plan toward the 12-month preexisting condition exclusion period. Charter's plan will begin paying for Art's diabetes care in 3 months (1 year minus 9 months). Art does not get credit for his coverage at Ajax since he had a break of *more than 63 consecutive days*.

- *A group health plan can count as preexisting conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice during the six-month period immediately before you joined that plan.* This period is called a **look back** period. In Montana, individual health plans can apply different rules to determine whether a condition is preexisting.

- *Under group health plans, coverage for preexisting conditions can be excluded for no more than 12 months.* However, if you enroll late in your group plan (after you were hired and not during a regular or special enrollment period), you may have a longer preexisting condition exclusion period. This period can be up to 12 months if you are a late enrollee in a fully insured **large group health plan**, and up to 18 months for late enrollees in all other group health plans.

- *Group health plans cannot apply a preexisting condition exclusion period for pregnancy, newborns, newly adopted children, children placed for adoption, or genetic information.*

- *No preexisting condition exclusion period can be applied without appropriate notice.* Your group health plan must inform you, in writing, if it intends to impose such a period. Also, if needed, it must help you get a certificate of creditable coverage from your old health plan.

- *Your protections may differ if you move to a group health plan that offers more benefits than your old one did.* Plans can look back to determine whether your previous health plan covered *prescription drugs, mental health, substance abuse, dental care,* or *vision care*. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a preexisting condition exclusion period for that category.

Even if coverage is continuous, there may be an exclusion for certain benefits

Sue needs prescription medication to control her blood pressure. She had 2 years of continuous coverage under her employer's group health plan, which did not cover prescription drugs. Sue changes jobs, and her new employer's plan does cover prescription drugs. However, because her prior policy did not, the new plan refuses to cover her blood pressure medicine for a year.

Question: Is this permitted?

Answer: Yes. However, the plan must pay for covered doctor visits, hospital care, and other services for Sue's high blood pressure. It also must pay for covered prescription drugs required for other conditions that were not preexisting.

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group insurance, you may want to buy an individual health plan. However, in Montana – as in most other states – you have limited guaranteed access to individual health insurance.

WHAT ARE MY RIGHTS WHEN BUYING INDIVIDUAL HEALTH INSURANCE?

- *Generally, your health status may determine whether you can buy an individual health plan.* Insurance companies in Montana can deny individual health insurance coverage or charge you a higher premium if you have a costly health condition.

- *Individual health plans cannot impose preexisting condition exclusion periods longer than 12 months.* Unlike group health plans, individual health plans can look back 3 years for evidence of a preexisting condition. Individual health plans also can apply exclusion periods to pregnancy. You can get credit for prior coverage that had similar or greater benefits if you do not have a lapse in coverage greater than 30 days. These rules about preexisting condition exclusion periods only apply in individual health plans that do not impose **elimination riders.** (See below.) No preexisting condition exclusion periods can be imposed if you are federally eligible.

- *Individual health plans can have elimination riders that exclude coverage indefinitely for preexisting conditions.* Individual health plans can look back 3 years for evidence of a preexisting condition, and then impose an elimination rider on that condition. You can apply to the health plan to modify or remove an elimination rider, though the plan is not obligated to do so. Elimination riders cannot be imposed retroactively.

- *If you have an individual plan, your coverage cannot be canceled because you get sick.* This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plans, continue to live in the plan service area. However, specific disease policies (such as those that cover only cancer) are not required to be guaranteed renewable in Montana.

- *If you are leaving your job and you had group coverage, you may be able to stay in your plan an extended time through COBRA.*

- *If you are leaving a fully insured group health plan, you can buy an individual health plan from the company that provided your group coverage.* This is called a conversion policy.

- *If you have been denied coverage because of your health status, you can buy individual coverage from MCHA.*

- *If you are federally eligible, you can also buy from MCHA.* You will not have a preexisting condition exclusion period.

To be federally eligible, you must meet certain criteria

No matter where you live in the U.S., if you are federally eligible you are guaranteed the right to buy individual health coverage of some kind with no preexisting condition exclusion periods. In Montana, you are guaranteed the right to buy coverage only from MCHA. To be federally eligible, you must meet all of the following:

- You must have had 18 months of continuous creditable coverage, *at least the last day of which was under a group health plan.*
- You also must have used up any COBRA or **state continuation coverage** for which you were eligible.
- You must not be eligible for Medicare, Medicaid, or a group health plan.
- You must not have health insurance.
- You must apply for health insurance for which you are federally eligible within 63 days of losing your prior coverage.

Your federally eligible status ends as soon as you enroll in an individual health plan, because the last day of your continuous health coverage must have been in a group plan. You can become federally eligible again by maintaining continuous coverage and rejoining a group health plan.

WHAT PLANS HAVE TO LET ME IN?

COBRA CONTINUATION COVERAGE

- *If your employer offers health benefits and has at least 20 workers, a federal law known as COBRA entitles you to continue in your employer's group health plan after you leave your job.* If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage.*

- *COBRA coverage generally lasts up to 18 months and cannot be renewed.* However, certain disabled people can opt for coverage up to 29 months, and dependents sometimes can extend it up to 36 months.

- *Usually, COBRA continuation coverage ends when you join a new health plan.* However, if your new plan has a waiting period or a preexisting condition exclusion period, you can keep whatever COBRA continuation coverage you have left during that period. For specifics, ask your former employer or contact the U.S. Department of Labor. (See page 18.)

- *To qualify as federally eligible, you must use up any COBRA continuation coverage available to you.*

OTHER CONTINUATION COVERAGE IN MONTANA

Montana permits certain individuals to continue coverage under their fully insured group health plan, even after they lose eligibility as a member of that group.

- *Disabled adult children can remain on their parent's fully insured group health plan if they meet certain requirements.* If you are in a fully insured group health plan that offers family coverage and you have a disabled child who is covered as your dependent, your child can remain on your policy upon reaching the age at which the plan normally terminates coverage for dependent children. Your adult child must be incapable of self-sustaining employment by reason of a disability and remain dependent upon you for support and maintenance.

  Proof of incapacity must be furnished to the plan within 31 days of the child reaching the age at which dependent coverage would normally end. The plan can require you to continue furnishing proof of disability and dependency in the future, but no more frequently than every 2 years.

- *If you lose your eligibility for coverage under a fully insured group health plan because of a reduction in your regular work schedule, you may be able to remain enrolled in your group health plan for up to 1 year.* This protection can apply, for example, if you change from full time to part time work, or if you take a sabbatical. However, your employer must agree to let you continue as a member of the group. Your premium must be equal to that charged for others in the group.

CONVERSION POLICIES

- *In Montana, if you have had coverage through an employer's fully insured group health plan for at least 3 months and you leave that job, you are eligible to buy conversion coverage.* This is an individual policy you get from the company that insured your employer's group plan. If you had family coverage under your prior group plan, your dependents can elect conversion coverage, as well.

- *The insurance company must offer as a conversion plan a choice of any group or individual health plan it customarily sells.* However, the insurer does not have to offer you health plans it sells only to associations. The premium for a conversion health plan cannot be more than twice as high as the premium customarily charged by the insurer for that health plan.

- *The insurance company also must offer you a conversion plan with the same coverage as the lowest-cost basic group health plan it sells to small employers.* The premium for this conversion health plan cannot be more than 150% of the premium customarily charged by the insurer for that health plan.

- *Conversion policy premiums may be much more expensive than your former group plan premiums.*

- *You do not need to be federally eligible to buy a conversion policy.*

MONTANA COMPREHENSIVE HEALTH ASSOCIATION (MCHA)

Montana maintains a high risk pool, called the Montana Comprehensive Health Association, to provide insurance for people with expensive health conditions. Family coverage is not available through MCHA. Each person must qualify for coverage separately.

- *If you are federally eligible, you can buy health insurance from MCHA without preexisting condition exclusion periods.* If you elected COBRA continuation coverage, you must first use it up before you can apply to MCHA as federally eligible.

- *If you are not federally eligible you can buy this insurance if you are a resident and can demonstrate proof of uninsurability.* You are considered uninsurable if you have been diagnosed with one of a list of serious health conditions (such as cancer or diabetes). You also are considered uninsurable if, in the 6 months prior to applying, you have been turned down for coverage by 2 insurance companies, or offered a plan with an elimination rider that excludes coverage for your preexisting condition.

In general, you cannot have MCHA coverage if you are eligible for any other health insurance except Medicare. However, if you are in MCHA and become eligible for another health plan that has a preexisting condition exclusion period, you can keep your MCHA coverage through the end of that exclusion period.

- *If you are not federally eligible, MCHA will exclude coverage for your preexisting condition for 12 months.* MCHA will look back 5 years before you enroll to see if you had a condition for which you actually received a diagnosis or medical advice or treatment. Unlike group health plans, MCHA can impose a preexisting condition exclusion period on pregnancy. MCHA will give you credit for prior continuous coverage if it included similar or greater benefits, and if you apply within 30 days of losing your prior coverage.

- *MCHA offers three plan options – two portability plans and a traditional plan.* Portability plan options are only available if you are federally eligible.

  Portability plans cover hospital and doctor services, lab and x-ray tests, home health care, maternity care, treatment for mental illness and chemical dependency, prescription drugs, and other benefits. Covered services have a lifetime limit of $1 million.

  Portability Plan Option 1 has a $500 annual deductible, requires a 30% copayment on covered services and limits your out-of-pocket spending for covered services to $2,000 annually. Portability Plan Option 2 has a $2,000 annual deductible, requires no copayment on covered services, and limits your out-of-pocket expenses for covered services to $2,000.

  If you are not federally eligible, traditional MCHA coverage is your only available option. Traditional plan coverage is similar to portability plans. However, traditional plan coverage for prescription drugs is limited to $1,000 per year, and there is no coverage for mental health or chemical dependency. The traditional plan has a $1,000 annual deductible, requires a 20% copayment on covered services, and limits your out-of-pocket expenses to $5,000.

  If you have Medicare, MCHA also offers a special carve out policy with its own premium. Call MCHA for more information about Medicare carve out coverage.

- *MCHA premiums vary based on the plan you choose and your age.* For example, for the 1997-98 plan year, monthly premiums for traditional coverage range from $96.11 for children to $382.94 for adults 60 and over. Monthly premiums for Portability Plan Option 1 range from $104.25 for children to $420.97 for adults 60 and over. Call MCHA for a brochure listing all coverage options and premiums.

CHAPTER 4
YOUR PROTECTIONS AS A SMALL EMPLOYER

Kassebaum-Kennedy extends certain protections to employers seeking to buy health insurance for themselves and their workers, including some protections covering small employers only. Montana has enacted reforms to expand some of these protections. Generally, small employers are those that employ 2-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Montana Department of Insurance to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ at least 2 but not more than 50 people eligible for health benefits, health insurance companies must sell you any **small group health plan** they sell to small employers. To determine the number of eligible employees, you pick a minimum standard of between 20 and 40 hours per week. Any of your employees who meet that weekly work standard must be counted as eligible employees by the insurer.

  Insurers can require that a minimum percentage of your eligible employees sign up for coverage. They can also require you to pay a minimum share of your workers' premiums. If you are buying a large group health plan for 51 or more eligible employees, your group can be turned down.

- *Your insurance cannot be canceled because someone in your group becomes seriously ill.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud, or if they are discontinuing that insurance product. In the latter case, they must give you a chance to buy other plans they sell to groups of your size.

WHAT PLAN CHOICES DO I HAVE?

- *Insurance companies that sell small group health plans in Montana must offer a standard plan and a basic plan.* Insurers can offer other health plans as well.

- *The standard plan must meet coverage requirements set by law.* A standard plan deductible cannot exceed $500 per person ($1,000 per family). Copayments cannot exceed 25%. The out-of-pocket limit on covered expenses cannot exceed $2,000 per person annually ($4,000 per family).

- *Coverage under basic plans must be less than under standard plans.* Basic plans must cover at least the benefits covered under MCHA traditional coverage, plus coverage for mammograms and treatment for chemical dependency and mental health. The insurance company will vary deductibles and copayments to give the basic plan benefits a lower value than the standard plan.

CAN I BE CHARGED MORE BECAUSE OF MY GROUP'S HEALTH STATUS?

- *Within limits, you can be charged higher premiums based on the health, risk, and demographic characteristics of your group.* For small employers, Montana limits the difference in premiums and the annual increase that can be charged.

- *For groups with more than 50 eligible employees, Montana does not limit premium variation or increases.*

- *If you have questions about your group health insurance premiums, contact the Montana Department of Insurance.* (See page 18.)

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are not eligible to buy a group health plan on your own (though you may be able to join another group health plan through a family member).* Therefore, the laws that protect employers' access to group health plans do not apply to you. Your access to health insurance is protected by the laws that apply to individuals. (See page 10.)

- *If you are self-employed and buy your own health insurance, you are eligible to deduct an increasing percentage of the cost of your premium from your federal income tax.* This deduction is 40% for 1997, and 45% for 1998 and 1999. The deduction will increase gradually until it reaches 100% in the year 2007.

A WORD ABOUT ASSOCIATION PLANS

- Some small employers, self-employed people, and other individuals buy health insurance through professional or trade associations. The laws applying to association health coverage can be different than those for other health plans. Check with the Montana Department of Insurance about your protections in association health plans.

FOR MORE INFORMATION...

As a summary, this guide will not answer every question for every person in every circumstance. In addition, it is not a substitute for legal advice. If you have more questions, contact the agencies listed below or consult an attorney.

For questions about *individual*, or *fully insured group health plans*, call

Montana Department of Insurance at

(800) 332-6148
(Montana calls only)

or
(406) 444-2040

For questions about the Montana Comprehensive Health Association, call

Blue Cross and Blue Shield of Montana, the MCHA plan administrator
at
(800) 447-7828, extension 8537

or
(406) 444-8537

For questions about self-insured group health plans or COBRA continuation coverage, call

U.S. Department of Labor
at
(816) 426-5131 (Kansas City Regional Office for Montana)

or
(202) 219-4337
(Division of Technical Assistance and Inquiries, Washington, D.C.)

or
Check the Internet for Department of Labor publications at
http://www.dol.gov/dol/pwba
or by calling
(800) 998-7542

Consumer guides for other states are on the Internet at
http://www.georgetown.edu/research/ihcrp/hipaa

HELPFUL TERMS

Affiliation Period. The time an HMO may require you to wait after you enroll and before your coverage begins. HMOs that require an affiliation period cannot exclude coverage of preexisting conditions under group health plans. Premiums cannot be charged during HMO affiliation periods. See also HMO.

Certificate of Creditable Coverage. A document provided by your health plan that lets you prove you had coverage under that plan. Certificates of creditable coverage will usually be provided automatically when you leave a health plan. You can obtain certificates at other times, as well. See also Creditable Coverage.

COBRA. Stands for the Consolidated Omnibus Budget Reconciliation Act, a federal law in effect since 1986. COBRA permits you and your dependents to continue in your employer's group health plan after your job ends. If your employer has 20 or more employees, you may be eligible for COBRA continuation coverage when you retire, quit, are fired, or work reduced hours. Continuation coverage also extends to surviving, divorced or separated spouses; dependent children; and children who lose their dependent status under their parent's plan rules. You may choose to continue in the group health plan for a limited time and pay the full premium (including the share your employer used to pay on your behalf). COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances. See also State Continuation Coverage.

Continuous Coverage. Health insurance coverage that is not interrupted by a significant lapse. When joining a group health plan, coverage is considered continuous if there is not a break of 63 or more consecutive days. When joining an individual health plan, coverage is considered continuous if there is not a break of 30 or more consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Creditable Coverage, Federally Eligible, Group Health Plan, Individual Health Plan.

Conversion. Your right, when leaving a fully insured group health plan in Montana, to convert your policy to an individual health plan. There are rules about the type of coverage that must be offered and the premiums that can be charged by conversion policies in Montana. See also Fully Insured Group Health Plan.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; an individual health plan; Medicare; Medicaid; CHAMPUS (health coverage for military personnel, retirees, and dependents); Federal Employees Health Benefits Program (FEHBP); Indian Health Service; Peace Corps; or a state health insurance high risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Plan.

Elimination Rider. A feature permitted in individual health plans that excludes coverage for a preexisting condition. Unlike preexisting condition exclusion periods, which can be no longer than 12 months, elimination riders can last indefinitely. Individual health plans can look back 3 years for evidence of a preexisting condition. You can apply to have an elimination rider modified or removed, but the health plan is not obligated to do so.

Enrollment Period. The period during which all employees and their dependents can sign up for coverage under an employer group health plan. Besides permitting workers to elect health benefits when first hired, many employers and group health insurers hold an annual enrollment period, during which all employees can enroll in or change their health coverage. See also Group Health Plan, Special Enrollment Period.

Federally Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be federally eligible, you also must have used up any COBRA or state continuation coverage available to you; you must not be eligible for Medicare, Medicaid, or a group health plan; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you are buying individual health coverage, federal eligibility confers greater protections on you than you would otherwise have in Montana and in other states. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured group health plans are regulated by Montana. See also Self-Insured Group Health Plans.

Genetic Information. Includes information about family history or genetic test results indicating your risk of developing a health condition. A group health plan cannot consider preexisting (and therefore exclude coverage for) a condition about which you have genetic information, unless that health condition has been diagnosed by a health professional. See also Group Health Plan.

Group Health Plan. Health insurance (usually sponsored by an employer, union or professional association) that covers at least 2 employees.

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. By federal law, all health plans sold to small employers are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

Guaranteed Renewability. A feature in most health plans that means your coverage cannot be canceled because you get sick. HIPAA requires health insurance to be guaranteed renewable. Your coverage can be canceled for other reasons unrelated to your health status. Disease-specific health plans (such as those covering only cancer) are not required to be guaranteed renewable in Montana.

Health Insurance or ***Health Plan***. In this guide, the term means benefits consisting of medical care (provided directly or through insurance or reimbursement) under any hospital or medical service policy, plan contract, or HMO contract offered by a health insurance company or a group health plan. It does not mean coverage that is limited to accident or disability income insurance, workers' compensation insurance, liability insurance (including automobile insurance) for medical expenses, or coverage for on-site medical clinics. Health insurance also does not mean coverage for limited dental or vision benefits to the extent these are provided under a separate policy.

Health Plan Year. That calendar period during which your health plan coverage is in effect. Many group health plan years begin on January 1, while others begin in a different month.

Health Status. When used in this guide, refers to your medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. See also Genetic Information.

HIPAA. The Health Insurance Portability and Accountability Act, better known as Kassebaum-Kennedy, after the two senators who spearheaded the bill. Passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets a national floor for health insurance reforms. Since states can and have modified and expanded upon these provisions, consumers' protections vary from state to state.

HMO. Health maintenance organization. A kind of health insurance plan. HMOs usually limit coverage to care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions. If you are covered under an HMO, the HMO might require an affiliation period before coverage begins. See also Affiliation Period.

Individual Health Plan. Policies for people not connected to an employer group. This term also refers to coverage purchased by the self-employed for themselves (or their family members) but for no other employees. Individual health plans are regulated by Montana.

Kassebaum-Kennedy. See HIPAA.

Large Group Health Plan. One with more than 50 eligible employees.

Late Enrollment. Enrollment in a health plan at a time other than the regular or a special enrollment period. Late enrollees can be subject to a longer preexisting condition exclusion period. See also Special Enrollment Period.

Look Back. The maximum length of time, immediately prior to enrolling in a health plan, that can be examined for evidence of preexisting conditions. The maximum look back permitted is different for individual and group health plans. See also Elimination Rider, Preexisting Condition.

MCHA. Montana Comprehensive Health Association, the state-run program for people with high health risks (called a high risk pool). MCHA sells individual coverage to those who are federally eligible and to people with serious health conditions who cannot buy coverage from private health insurance companies.

Nondiscrimination. A requirement that group health plans not discriminate against you based on your health status. Your coverage under a group health plan cannot be denied or restricted, nor can you be charged a higher premium, due to your health status. Group health plans can restrict your coverage based on other factors (such as part time employment) that are unrelated to health status. See also Group Health Plan, Health Status.

***Preexisting Condition* (Group Health Insurance).** Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Pregnancy cannot be counted as a preexisting condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a preexisting condition. Newborns, newly adopted children, and children placed for adoption covered within 30 days cannot be subject to preexisting condition exclusions.

***Preexisting Condition* (MCHA).** Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 5-year period immediately preceding enrollment in a health plan. Pregnancy can be counted as a preexisting condition by MCHA. No preexisting condition exclusion periods can be applied if you are federally eligible. See also Federally Eligible.

***Preexisting Condition* (Private Individual Health Insurance).** Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 3-year period immediately preceding enrollment in a health plan. In Montana, under individual health insurance policies, pregnancy can be counted as a preexisting condition. No preexisting condition exclusion periods can be applied if you are federally eligible. See also Federally Eligible.

Preexisting Condition Exclusion Period. The time during which a health plan will not pay for covered care relating to a preexisting condition. See also Preexisting Condition.

Self-Insured Group Health Plans. Plans set up by employers who set aside funds to pay their employees' health claims. Because employers often hire insurance companies to run these plans, they may look to you just like fully insured plans. Employers must disclose in your benefits information whether an insurer is responsible for funding, or for only administering the plan. If the insurer is only administering the plan, it is self-insured. Self-insured plans are regulated by the U.S. Department of Labor, not by Montana.

Small Group Health Plans. Plans with at least 2 but not more than 50 eligible employees.

Special Enrollment Period. A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 days. Enrollment in a health plan during a special enrollment period is not considered late enrollment. See also Late Enrollment.

State Continuation Coverage. A program similar to COBRA for small employers. Montana does not have a state continuation coverage law. However, certain individuals are eligible for continuation coverage in fully insured group health plans in Montana. See also COBRA.

Waiting Period. The time you may be required to work for an employer before you are eligible for health benefits. Not all employers require waiting periods. Waiting periods do not count as gaps in health insurance for purposes of determining whether coverage is continuous. If you employer requires a waiting period, your preexisting condition exclusion period begins on the first day of the waiting period.

State Auditor Mark O'Keefe
also has the following consumer guides available free to all Montanans:

- Health Insurance Buyer's Guide
- Auto Insurance Buyer's Guide
- Life Insurance Buyer's Guide
- Home Insurance Buyer's Guide
- Long Term Care Buyer's Guide
- Montana Buyer's Guide to Medicare Supplemental Insurance

IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT INSURANCE, CALL STATE AUDITOR MARK O'KEEFE AT 1-800-332-6148, OR (TDD) 406-444-3246.
FAX 1-406-444-3497
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